STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040002	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	200 SW 14TH NEWTON, KS 67114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint number 189065 for the above named facility conducted on 08/06/24 and 08/07/24.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (a) The facility reported a census of 15 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on interview and record review the Administrator failed to ensure all findings determining R1's functional capacity was recorded on a screening form specified by the department. Findings included:	S3080		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040002	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	200 SW 14TH NEWTON, KS 67114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3080	Continued From page 1 - Record review for R1 revealed an admission date of 02/01/21 with diagnoses of type two diabetes mellitus, essential hypertension, major depressive disorder, altered mental status, and dizziness and giddiness. Review of R1's "Functional Capacity Screen" (FCS) dated 03/08/24 revealed R1 required supervision with bathing, and physical assistance with management of her mediations. She was able to make herself understood and she understood others, and she used a walker mobility device. The cognition section of the FCS lacked documentation. Interview on 08/06/24 at approximately 12:50 PM with Administrator A and "Licensed Nurse" (LN) B confirmed the "Cognition" section of R1's "Functional Capacity Screen" lacked documentation of R1's cognition level at the time of the screening. The Administrator failed to ensure all findings from the screening determining R1's functional capacity was recorded on the screening form specified by the department.	S3080		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040002	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	200 SW 14TH NEWTON, KS 67114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 2 by: K.A.R. 26-41-204 (i) The facility reported a census of 15 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on observation, interview and record review the Administrator failed to provide healthcare services for R1 in accordance with professional standards of practice when Administrator A failed to conduct a an assessment of R1's bed assist device to ensure the device posed no risk for entrapment, confirmed the device was not a restraint, and assessed R1's ability to safely use the bed assist device. Findings included: - Record review for R1 revealed an admission date of 02/01/21 with diagnoses of type two diabetes mellitus, essential hypertension, major depressive disorder, altered mental status, and dizziness and giddiness. Review of R1's "Functional Capacity Screen" (FCS) dated 03/08/24 revealed R1 required supervision with bathing, and physical assistance with management of her mediations. She was able to make herself understood and she understood others, and she used a walker mobility device. The cognition section of the FCS lacked documentation, and the comments section lacked documentation of a bed assist device. Review of R1's combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) identified the facility staff would perform glucose	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040002	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	200 SW 14TH NEWTON, KS 67114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 3	S3171		

checks as ordered and check her vital signs weekly and her weight monthly. R1's daughter would prepare her medications and R1 would self-administer her medications.

The combined NSA/HSP lacked a description of the bed assist device, its purpose and any special instructions on use and monitoring of the device.

R1's record lacked the documentation of an assessment being performed to confirm the device was not a restraint, R1's ability to safely use the device and documentation of the findings in R1's record.

Observation on 08/06/24 at approximately 12:30 PM of R1's bed reveled on the left side on the head of the bed ,was an inverted "U" shaped device that measured 12 inches in width and 20 inches from the top of the device to the bottom of the device which was slid under the mattress. The device had a zip tie on each of the legs of the device anchoring it to the bed frame.

Interview on 08/06/24 at approximately 12:50 PM with Administrator A and "Licensed Nurse" (LN) B confirmed R1's record lacked documentation of an assessment being performed to confirm the device was not a restraint, R 1's ability to safely use the device and documentation of the findings in R1's record.

The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended the following:

Complete an assessment of the resident to confirm that the device is not a restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N040002	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	200 SW 14TH NEWTON, KS 67114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 4 Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The Administrator failed to provide healthcare services for R1 in accordance with professional standards of practice when Administrator A failed to conduct a an assessment of R1's bed assist device to ensure the device posed no risk for entrapment, confirmed the device was not a restraint, and R1's ability to safely use the bed assist device.	S3171		